



## **CONRAD STATE 30 J-1 VISA STATE OF KANSAS REQUESTING NATIONAL INTEREST WAIVER LETTER OF SUPPORT**

The Kansas Department of Health and Environment will provide a letter of support for J-1 physicians in good standing. Each National Interest Waiver request will be considered on an individual basis. To obtain a letter of support, the following items must be submitted:

1. National Interest Waiver Request Form and all required documentation
2. Copy of current employment contract
3. The physician must submit a statement that includes:
  - Full name
  - Date of Birth
  - Kansas Medical License Number
  - Employment Site
  - Description of services to be provided in the HPSA/MUA
  - Description of how approval of the waiver is in the national interest
4. The sponsoring employer must submit a letter that includes:
  - Full name of physician
  - Facility name and address
  - Verification that the physician is in good standing
  - Description of services physician will provide
  - Documentation of need for the physician's services
  - Affirmation that physician will practice full-time (40 hours per week) in a HPSA/MUA
  - Describe the effects of denial of the National Interest Waiver to the facility and to the HPSA/MUA.
5. Submit the required information to:  
Attn: J-1 Visa Waiver Review Program  
State Primary Care Office  
KDHE Bureau of Community Health Systems  
1000 SW Jackson, Suite 340  
Topeka, KS 66612-1365

Please inform our office upon approval of the National Interest Waiver. Thank You.



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## NATIONAL INTEREST WAIVER REQUEST FORM

### PHYSICIAN:

Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_ Origin of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ Kansas Medical License # \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Start work date: \_\_\_\_\_ Practice Specialty \_\_\_\_\_

Please provide a written statement that:

- Describes the need for your services in the HPSA/MUA
- Describes how approval of the waiver is in the national interest

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### SPONSORING EMPLOYER:

Name of Employment Site: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_ County: \_\_\_\_\_

HPSA ID: \_\_\_\_\_

The sponsoring employer must submit a letter that includes:

- Full name of physician
- Site name and address
- Verification that the physician is in good standing
- Description of services physician will provide
- Documentation of need for the physician's services
- Affirmation that the physician will practice full-time (40 hours per week) in a HPSA or MUA
- Description of the effects of denial of the National Interest Waiver to the facility and to the HPSA/MUA

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Please submit a copy of the current employment contract along with the above information to:

Attn: J-1 Visa Waiver Review Program  
State Primary Care Office  
KDHE Bureau of Community Health Systems  
1000 SW Jackson, Suite 340  
Topeka, KS 66612-1365